STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure corridor walls were separated by walls constructed with a least 1/2 hour fire resistance rating. The findings included: Observation on November 8, 2010 at 10:00 a.m. revealed wall penetration in the north nurses station janitors closet and in the riser room.	K 017	**K 017 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. Penetrations were corrected. Maintenance department made rounds to ensure no penetrations are present. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Education was given to maintenance staff on 11-24-10 the importance of ensuring that penetrations are not present. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Weekly rounds will be conducted by maintenance supervisor or designee to ensure no penetrations are present throughout the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Weekly rounds will be reviewed by the executive director ensure compliance with Life Safety Code. Weekly round finding will be taken to the PI meeting by the ED monthly for the next 3 months which consists of: M.D., D.O.N.,ADON Rehabilitation, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping Beginning Dec.7 2010.	12/25/10
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	12-1-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation the facility failed to assure doors protecting corridor openings are substantial doors constructed of 1 3/4 inch solid bonded core wood. The findings included: Observation on November 8, 2010 at 11:00 a.m. revealed the south central bath on the 300 hall, the central bath on the 300 hall, the clean utility at the north nurses station and the kitchen/dining room doors were severely damaged and must be replaced.	K 018	**K 018 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. The maintenance supervisor made rounds and all damaged fire doors have been ordered and will be replaced. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Education was given to maintenance staff on 11-24-10 the importance of ensuring that fire-rated doors are not damaged. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Weekly rounds will be conducted by maintenance supervisor or designee to ensure that fire-rated doors are not damaged. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Weekly rounds will be reviewed by the executive director ensure compliance with Life Safety Code. Weekly round finding will be taken to the PI meeting by the ED monthly for the next 3 months which consists of: M.D., D.O.N.,ADON Rehabilitation, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping Beginning Dec.7 2010.	12/25/10
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least	K 027		

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K 027	Continued From page 2 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure smoke doors were provided with a 20 minute fire protection rating. The findings included: Observation on November 8, 2010 at 1:00 p.m. revealed all smoke doors in the facility were not provided with 20 minute fire protection rating labels.	K 027	**K 027 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. Doors were ordered and will have the fire protection rating labels. **Residents identified as having the potential to be affected by the same deficient practice.** **What corrective actions will be taken?** All residents have a potential to be affected. Education was given to maintenance staff on 11-24-10 on the importance of ensuring that all smoke doors have fire protecting ratings and their labels. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Weekly rounds will be conducted by maintenance supervisor or designee to ensure all smoke doors have fire protecting ratings and their labels.	12/25/10
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Weekly rounds will be reviewed by the executive director ensure compliance with Life Safety Code. Weekly round finding will be taken to the PI meeting by the ED monthly for the next 3 months which consists of: M.D., D.O.N.,ADON Rehabilitation, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping Beginning Dec.7 2010.	

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure all hazardous areas are provided with 3/4 hour fire rated doors and construction. The findings included: Observation on November 8, 2010 at 2:00 p.m. revealed the soiled linen/utility on the 100 hall and 300 hall and the clean linen on the 300 hall were provided with doors that were severely damaged and must be replaced. Further observation on November 8, 2010 at 3:00 p.m. revealed the smoking room ceiling was constructed of unrated plywood.	K 029	**K 029 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. Penetrations were corrected. Ceiling was repaired with ½ hour fire resistant materials to meet Life Safety Standard. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Education was given to maintenance staff on 11-24-10 on the importance of ensuring that all corridors are equipped with ¾ hour fire rated materials. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Weekly rounds will be conducted by maintenance supervisor or designee to ensure all corridors are equipped with ¾ hour fire rated materials. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Weekly rounds will be reviewed by the executive director ensure compliance with Life Safety Code. Weekly round finding will be taken to the PI meeting by the ED monthly for the next 3 months which consists of: M.D., D.O.N.,ADON Rehabilitation, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping Beginning Dec.7 2010.	12/25/10
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure HVAC systems comply with NFPA 90A. The findings included: Observation and testing on November 8, 2010 at 3:30 p.m. revealed the supply and exhaust in the	K 067		

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K 067	Continued From page 4 smoking room do not run continuously.	K 067	**K 067 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. Exhaust fan now runs continuously. Maintenance department made rounds to ensure exhaust fans run at all times. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Education was given to maintenance staff on 11-24-10 on the importance of ensuring exhaust fans are on at all times. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Weekly rounds will be conducted by maintenance supervisor or designee to ensure exhaust fans are on at all times. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Weekly rounds will be reviewed by the executive director ensure compliance with Life Safety Code. Weekly round finding will be taken to the PI meeting by the ED monthly for the next 3 months which consists of: M.D., D.O.N.,ADON Rehabilitation, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping Beginning Dec.7 2010.	12/25/10